



Female Genital Mutilation

Capacity building & knowledge sharing;
Focus groups with Migrant women in Malta

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In the last seven years Malta has been receiving migrants from African countries with a high prevalence of FGM. Two hundred forty-two women from these countries arrived in 2008 alone. This presents a challenge to health professionals within the Maltese health system in the Gynaecology and Obstetrics department who are increasingly faced with the issue of FGM among African women. On the other hand the women, victims of FGM, are encountering a totally different approach to their reproductive needs due to the existing cultural barriers between themselves and the health professionals.

The two focus group sessions were requested by the Units Leader – Assistance and Welfare to Asylum Seekers (AWAS). Coordination was taken up by the community worker and the coordinator/social worker of two open centres in collaboration with the Migrant Health Coordinator (Department of Primary Health) and Medecins Sans Frontières (MSF). The objectives of these two qualitative focus groups were to:

- ❖ Give women migrants the opportunity to share their experiences of FGM
- ❖ To explore their perceptions and problems associated with it
- ❖ To generate recommendations expressed by the experiences and suggestions of migrant women to health professionals working in Obstetrics and Gynaecology unit at Mater Dei Hospital and Health Centres in Malta, with the aim to improve the care given to this population group.

Background information

Female genital mutilation (FGM) is a pressing concern as it violates basic human rights for women. FGM also known as the female circumcision is a harmful practice and has serious short and long term consequences on the health of women. The procedure is usually performed by an unskilled traditional practitioner who use pieces of broken glass, sharp stones, razors or used blades as a cutting tool, without anaesthesia. In some affluent societies the procedure may be performed in hospital as a medicalised procedure however, the short and long term consequences of FGM remain. It is often enforced by mothers and other female family members to ensure that the girl is being well prepared for the only social status a woman can ever have in such countries – marriage.

According to the WHO (2008) there are 4 types of FGM:

1. **Type 1** (commonly referred to as clitoridectomy): Excision (removal) of the clitoral hood with or without removal of all or part of the clitoris.
2. **Type 2** (commonly referred to as excision): Excision (removal) of the clitoris together with part or all of the labia minora. This is the most widely practiced form.
3. **Type 3** (commonly referred to as infibulation): Excision (removal) of part or all of the external genitalia (clitoris, labia minora and labia majora) and stitching or narrowing of

the vaginal opening, leaving a very small opening, about the size of a matchstick, to allow for the flow of urine and menstrual blood.

4. Type 4

- ❖ Pricking, piercing or incision of the clitoris and/or labia.
- ❖ Stretching the clitoris and/or labia.
- ❖ Cauterization by burning of the clitoris and surrounding tissues.
- ❖ Scraping of the vaginal orifice or cutting of the vagina.
- ❖ Introduction of corrosive substances into the vagina to cause bleeding, or introduction of herbs into the vagina to tighten or narrow the vagina.

FGM can have devastating and harmful consequences for a woman throughout her life. The health problems a girl can experience depend a great deal on the severity of the procedure, the sanitary conditions in which it was performed, the competence of the person who performed it and the strength of the girl's resistance. In cases where the procedure is carried out in unsanitary conditions and unsterile equipment is used, the dangers of infection are high, sometimes leading to death.

Focus Group Sessions

The main speaker (Migrant Health Unit coordinator) conducted the two sessions with the participation of a health promoter from MSF. To overcome language and cultural barriers three cultural mediators (2 Somalis and 1 Eritrean) facilitated the discussions by translating verbal statements and bridging the gap between cultures.

Session 1 was held in one of the open centres in the central part of the island, in the children's playroom where most health education sessions usually take place. The seating was arranged in a circular fashion so that everyone could see each other. Only women were asked to attend for this session. Attendance was voluntary and women could decline to continue their participation in the discussion at any time. It was decided to commence the session at 11.30 am to give the women enough time to go to the Friday market to buy fruit and vegetables. A total of eight (8) women (7 Somalis and 1 Ethiopian) attended the session which lasted 2 hours. The participants who turned up for this focus group were all mothers. Two boys, who were the sons of one of the participant ages 4 and 5, remained with the mother in the room. They were given crayons and paper so that their mother could be free to participate.

In the second focus group this session was held in the hall of another open centre situated towards the south of Malta. The seating arrangement was the same as with the first group. For this session a total of fourteen (14) Somali women and one (1) Eritrean turned up. An Eritrean cultural mediator was also present for this session.

The targeted population for both focus groups was all the women residing at these residential homes, who are mostly Somalis. Since this group of women is known to be more of an auditory audience (Ahmed, 2002) it was decided that no power-point presentation was to be used. Instead a white board and a coloured pen were used to highlight important points and to draw diagrams during the session.

Although the speaker is quite known to the residents, especially to those in the first group, due to previous health education sessions at these residential homes, the nature of the topic warranted a careful approach to reach the following objectives:

- ❖ To raise awareness about the physiological and psychological harm caused by FGM
- ❖ To explore the perception of migrants surrounding FGM and its complications
- ❖ To explore the care given to women with FGM at Mater Dei hospital
- ❖ To empower the women to eliminate the practice of FGM
- ❖ To engage the participants to contribute to the discussion
- ❖ To share knowledge with health and social care professionals

The speaker had three main concerns about this issue: to her knowledge the subject is a taboo and migrants do not speak freely about it, her own limited knowledge about the topic and finding a way to encourage an interactive atmosphere to engage all the participants to contribute to the discussion.

Together with the health promoter and the cultural mediators, the migrant health coordinator introduced herself, greeted the women and thanked them for their attendance. The discussion started off by explaining that there were only women in the room because the topic was an issue pertaining to women and everyone was free to contribute to the discussion. She also admitted how little she knew about this topic and asked the participants to be part of this exchange of knowledge.

The first points to be mentioned from the main speaker's knowledge were: there are 4 types of FGM (type 3 and 4 being the most drastic procedures); it is a procedure done to girls at a young age (new born to 14 years) in certain countries, it is illegal in the western world and that it often leads to certain anatomical and physiological difficulties/problems such as:

- ❖ Micturition problems
- ❖ Menstruation problems
- ❖ Problems during sexual activity
- ❖ Problems in giving birth

These points, which were listed on the white-board, generated a lot of discussion among the women themselves. Most of the Somali women, who confirmed that they all suffered from these symptoms pointed out that although they have attended the Antenatal/Gynaecology Clinic at some point during their stay in Malta, they were never asked about these symptoms or the issue of FGM during their visits. According to Raynor and Morgan (2000) midwifery text books lack clear guidelines on how to provide best care for women who have been genitally mutilated.

Since none of the women could speak English the cultural mediator, an outstanding cultural broker, patiently translated their verbal statements in English. The latter could also speak Arabic which she used to translate for the Ethiopian lady. The Ethiopian lady stated that FGM is not an issue in her country of origin nevertheless, she decided to stay on for the session. The Somali participants claimed that they all had been circumcised when they were young girls and although they stated that FGM is not being enforced as much as it used to be many years ago by Somalis living in the cities, FGM (Types 3 and 4) are still widely performed especially on girls coming from families who live in rural areas of Somalia.

The speaker continued to share her restricted cultural knowledge surrounding FGM by stating that, according to some studies that she had read, FGM is carried out due to pressure from female family members who strongly lay emphasis on the procedure 'for the good' of the girl's future. The Somali women coming from a rural area in Somalia affirmed that women who are not infibulated will not get married (marriage being the only recognized social status available to women) and will not be accepted by the future husband's family as she will not be considered to be pure (a virgin). Therefore, social pressure in these societies is important to maintain a certain peace of mind to mothers of daughters when their time to get married arrives. However, this was not confirmed by the other women who according to the cultural mediator had accents which indicate that they come from cities in Somalia.

FGM – perceptions of parents

When asked if the issue of FGM is discussed with their husband the women stated that the men's opinions are changing nowadays and that their husbands do not want their daughters to be infibulated. However, they also stated that a man is only after his needs, even if the woman is in pain or has physiological discomforts.

When the women present for the focus groups were asked if they would have the procedure done to their daughters, the room filled with a collective chorus and hand-waving by the majority of the mothers, indicating that they will never cause such suffering to their daughters. However, two women claimed that they would have the procedure done so that the daughter will not have problems relating to marriage when she grows up. Another mother said she will not have the drastic procedure done to her daughter (type 3 and 4); but will settle for type 1 where the hood of the clitoris is excised together with part or all of the labia minora (the inner vaginal lips). It was explained to the mother that although the harm was minimal when compared to the other types of FGM, it was still an abuse on the child's person and it impeded her from experiencing sexual pleasure for rest of her life. According to the mother, she felt it was her duty to bestow modesty on her daughter. This issue was also echoed by the Eritrean lady in the second focus group who said that her mother and elderly female relatives put pressure to enforce the practice of FGM because it is understood that if the clitoris remains intact the girl would feel the need to go around with a number of men due to her high sexual desire. According to female elders 'The closing of the vagina in circumcision is understood as a way to close or make whole those parts of the body that are seen to be 'loose' or rebellious' (Hernandez, 2007). At this stage the health promoter suggested that the issue could be tackled by doing away with harm but enforcing high moral standards within the family instead of causing physical and mental trauma to the child.

These interventions presented a challenge to the speaker and health promoter to make the woman understand that harm should not be done to children at such a tender age when they cannot decide for themselves. It was explained that although western women do modify their body to please men, which is another form of pressure, they do so when they are of an age to give consent. It is not clear whether the meaning of consent was fully understood by all women since women never have to consent to anything in their country of origin. On acknowledging the limited possibility to change the mentality of a population group overnight, it was decided that we would allow the woman to digest

what was said during the session and then the subject could be brought up again on another occasion.

Later on the speaker drew a diagram of a foetus in the uterus to steer the discussion towards the delivery of a newborn baby in relation to FGM. The diagrams of the normal female genitals and that of the infibulated female genitals were drawn up to point toward the different approaches health professionals in maternity care need to take into consideration when taking care of pregnant women with or without FGM.

Three of the Somali women had undergone a caesarean section in Malta. In Somalia, women express strong fear with regard to caesarean births (Carroll *et al.* 2007) because it is thought that this procedure can limit the number of children a woman may be able to carry safely (Hernandez, 2007). It must be understood by health care professionals that a woman's status is enhanced by having a number of children (Rydal & Hodeida, 1998). While in the western society women draw their social status from their educational and economical well-being, in Somalia, women draw their social status from the number of children; especially male children (Folio, 1999; Ethno med, 1996). Furthermore, resistance to caesarean section could have risen because Somali women have a lot of confidence in their own bodies (Hernandez, 2007) and birth is understood as a natural process that does not normally require intervention. In this context CS has the potential to jeopardise and undermine this understanding.

The three women understood that the decision regarding caesarean section was taken due to complications they had developed at some stage during the delivery: one lady had high diastolic blood pressure, the second had her baby in breach position and the third one had a prolonged labour leading to foetal distress.

One participant highly expressed her anxiety that being in 'coma' during caesarean section could have had a negative impact on the newborn. The mother was reassured that coma and being under the effect of anaesthesia are two separate things; while the former indicates a neurological impairment the latter is a short-lasting chemical sedation. The three mothers said that during the delivery they were accompanied by relatives or friends who could speak English to facilitate communication with health care professionals. At this stage the speaker found the opportunity to stress the point that consent from the mother is an important routine procedure of the hospital. In signing the consent form the mother is giving permission to the health professionals to administer treatment and perform the necessary procedures during the stages of labour. It was also emphasized that signing the consent form does not mean that a caesarean section will be performed without the need for it.

The three women who had undergone a caesarean section stated that the Maltese doctors gave them enough time to allow them the possibility to have a normal delivery, but then had to act accordingly for the good of the baby and the mother.

In comparison to this, two women in the second focus group who had normal deliveries stated that doctors often wait too long and they had suffered what they described as third and fourth degree perineal tears. According to Vangen *et al.* (2003) neglect of circumcision may lead to adverse birth outcomes including unnecessary caesarean sections, prolonged second stage of labour and low Apgar scores.

In contrast to this the Somali cultural mediator who has attended to more than fifty women within ANC, GYN and OBS department at Mater Dei Hospital agrees that there is widespread fear of caesarean section in the Somali community. Within the Maltese context Somali women believe that if the mother goes to hospital too early before the baby is due, it is more likely for the woman to have a CS, which is why they often prefer to present themselves at the delivery suite very late. There is also the belief that women are given little time to give birth in Malta and the health care workers do not know how to respond to the needs of victims of FGM. FGM requires that doctors and other health professionals familiarize themselves with the practice and the cultural beliefs underlying it (Kanguom *et al*, 2003).

When asked whether the participants would like to be given a choice of being de-infibulated during their antenatal visits or after delivery, this issue was not of primary concern to the mothers in the first focus group but the women in the second group thought that infibulated women should be offered this service. In fact two young twenty-year old girls one of whom got married 5 months ago approached the facilitators after the session to ask how they can go about having a de-infibulation procedure. Both girls were experiencing very painful sexual intercourse and were very scared of giving birth in the eventuality of a pregnancy.

On accompanying several women to the delivery suite in Malta, the cultural mediator observed that the possibility of de-infibulation is not common practice in Malta. A de-infibulation service should be available, and easily accessible to those who may need it. Apart from the usual screening and antenatal care, it is important to provide pregnant women with support specific to their needs including those surrounding FGM (RCN.2006).

It is not known whether Maltese laws include any specification concerning the issue of re-infibulation. In six European countries (Austria, Belgium, Denmark, Spain, Sweden and the United Kingdom) re-infibulation is illegal. Three of these countries: Denmark, Sweden and the UK are provided with national guidelines with regard to the issue of re-infibulation. Policy guidelines for nurses and midwives state that:

' health workers must not, under any circumstances, close up (re-infibulate) an opened vulva in a girl or woman with type 3 FGM in a manner that makes intercourse and childbirth difficult'

(WHO, 2001)

Recommendations given by participants

During the focus groups the women expressed important specific needs:

- ❖ They would like to discuss the options they may have regarding de-infibulation prior to pregnancy, during pregnancy and/or after delivery
- ❖ A majority of patients would like the health care provider to take more time during the medical consultation

- ❖ They wish to receive more empathic care by health professionals
- ❖ participants feel that they would ask more questions to understand the care being given by doctors and midwives if a cultural mediator was available
- ❖ They would like health professionals to be more knowledgeable about how to provide care for women with FGM so that the issue could be discussed with the mothers rather than neglected.

Recommendations for health professionals

- ❖ Better awareness of FGM in the sub-Saharan migrant population including knowledge about the different types of FGM and the long-term complications during the taking of a complete medical history. Sexual complications of FGM might not be actively addressed by women concerned, but they should be probed by the gynaecologist/obstetrician and midwives
- ❖ In order to provide care in a culturally sensitive manner, it is important to have some information on the socio-cultural background of the practice of FGM
- ❖ The issue of de-infibulation needs to be discussed with each pregnant woman presenting with FGM type 3 and possibly involving her partner. Some African communities (Somalis) tend to be an auditory group and therefore the procedure and the expected outcome should be explained to her with the help of a mirror and anatomical drawings rather than giving printed material.
- ❖ An infibulated woman, who visits the unit for a reason other than pregnancy should be informed about the possibility of de-infibulation.
- ❖ Many migrant women feel great shame during a gynaecological examination by a male doctor - a gender sensitive medical consultation (including the cultural mediator) should be offered to women concerned especially with regards to FGM
- ❖ A professional cultural mediator should be offered where necessary
- ❖ Health care providers should be more active in addressing the daughter's future with respect to FGM to guarantee the bodily integrity of the child, taking an important step towards abolishing FGM
- ❖ Training on medical, social and cultural aspects of FGM should be included in the curricula of medical and nursing study programmes.
- ❖ Work towards a specific law against FGM and re-infibulation

Conclusion

The focus groups which were highly interactive generated a lot of discussion. They were able to highlight important issues for everyone present for these activities. This

information will be disseminated to midwives and gynaecologists following a meeting with the Obstetrics and Gynaecology director at Mater Dei Hospital to make known the recommendations expressed by the participants to improve the quality care given to victims of FGM.

The experiences of Somali community members varies greatly with regard to FGM, depending on whether they lived in rural or urban communities in Somalia, how long they have been in the host country, their former occupation and level of education. The impression that many young men and women are changing their ideas about performing the radical procedure of FGM on their daughters shows that traditions are changing over the years in countries where the influence of the elderly is strongly upheld. However, more education is needed to reach longstanding attitudes surrounding FGM of women who are pressured by the collective decisions made by the elderly in many African societies.

These focus groups also sought to eliminate the misconception of most Somali women that caesarean section is a very dangerous procedure and that the only purpose of signing a consent form at Mater Dei Hospital pertains to consenting for a caesarean section.

The two sessions to which the migrant women actively contributed lasted 2 hours each. The women were thanked for their attendance and their input during the discussion which has led to heightened further knowledge on cultural issues surrounding FGM.

The author would like to thank all the Somali and Eritrean and Ethiopian women who participated in the focus groups for their valid contribution during the two highly interactive and stimulating discussions. Thanks also goes to the health promoter and the cultural mediators and last but not least the community workers/ coordinator /Social worker from the two open centres (AWAS)

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